

[ORIGINAL]

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DEC 21 2015

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
CERTIFICATE OF EXEMPTION APPLICATION

HEALTH FACILITIES &
SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

E-037-15

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Memorial Hospital		
Street Address:	4500 Memorial Drive		
City and Zip Code:	Belleville, IL 62226		
County:	St. Clair	Health Service Area	XI Health Planning Area: F-01

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Protestant Memorial Medical Center d/b/a/ Memorial Hospital		
Address:	4500 Memorial Drive Belleville, IL 62226		
Name of Registered Agent:			
Name of Chief Executive Officer:	Mark J. Turner		
CEO Address:	4500 Memorial Drive Belleville, IL 62226		
Telephone Number:	618/257-5642		

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship
		<input type="checkbox"/>	Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

[Person to receive ALL correspondence or inquiries)

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
CERTIFICATE OF EXEMPTION APPLICATION**

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City and Zip Code:	Belleville, IL 62226		
County:	St. Clair	Health Service Area	XI Health Planning Area: F-01

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Memorial Group, Inc.
Address:	4500 Memorial Drive Belleville, IL 62226
Name of Registered Agent:	
Name of Chief Executive Officer:	Mark J. Turner
CEO Address:	4500 Memorial Drive Belleville, IL 62226
Telephone Number:	618/257-5642

Type of Ownership of Applicant/Co-Applicant

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Company Name:	
Address:	
Telephone Number:	
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Fax Number:	

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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Street Address:	4500 Memorial Drive		
City and Zip Code:	Belleville, IL 62226		
County:	St. Clair	Health Service Area	XI Health Planning Area: F-01

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	BJC Healthcare
Address:	4901 Forest Park Avenue St. Louis, MO 63108
Name of Registered Agent:	
Name of Chief Executive Officer:	Steven H. Lipstein
CEO Address:	4901 Forest Park Avenue St. Louis, MO 63108
Telephone Number:	314/286-2030

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
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		<input type="checkbox"/>	Other

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Additional Contact

[Person who is also authorized to discuss the application for permit]

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**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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City and Zip Code:	Belleville, IL 62226		
County:	St. Clair	Health Service Area	XI Health Planning Area: F-01

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Memorial Regional Health Services, Inc.
Address:	4500 Memorial Drive Belleville, IL 62226
Name of Registered Agent:	
Name of Chief Executive Officer:	Mark J. Turner
CEO Address:	4500 Memorial Drive Belleville, IL 62226
Telephone Number:	618/257-5642

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
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Telephone Number:	847/776-7101
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Fax Number:	847/776-7004

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960

Name:	Michael McManus
Title:	Chief Operating Officer
Company Name:	Memorial Hospital
Address:	4500 Memorial Drive Belleville, IL 62226
Telephone Number:	618/233-7750
E-mail Address:	mmcmanus@msmhosp.com
Fax Number:	618/257-5658

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Protestant Memorial Medical Center, Inc.
Address of Site Owner:	4500 Memorial Drive Belleville, IL 62226
Street Address or Legal Description of Site:	4500 Memorial Drive Belleville, IL 62226
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.	
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name:	Protestant Memorial Medical Center, Inc.				
Address:	4500 Memorial Drive Belleville, IL 62226				
<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership		
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental		
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship	<input type="checkbox"/>	Other
<ul style="list-style-type: none">o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.					
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.					

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.
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Flood Plain Requirements

NOT APPLICABLE

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 (<http://www.hfsrb.illinois.gov>).

APPEND DOCUMENTATION AS **ATTACHMENT -5**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

NOT APPLICABLE

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS **ATTACHMENT-6**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

NOT APPLICABLE

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

Substantive

Non-substantive

2. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does **NOT** have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The applicants propose to discontinue Memorial Hospital's Pediatrics category of service through the Certificate of Exemption (COE) process. Memorial Hospital is currently approved to operate fourteen Pediatrics beds. Following discontinuation, the hospital will continue to provide outpatient pediatrics services, will treat pediatrics patients in the hospital's Emergency Department, and will admit selected, older pediatric patients to its Medical/Surgical units, as clinically-appropriate.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$0	\$0	\$0
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$0	\$0	\$0
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Purchase Price: \$ _____
Fair Market Value: \$ _____
The project involves the establishment of a new facility or a new category of service <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.
Estimated start-up costs and operating deficit cost is \$ _____.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.
Indicate the stage of the project's architectural drawings: <input checked="" type="checkbox"/> None or not applicable <input type="checkbox"/> Preliminary <input type="checkbox"/> Schematics <input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): _____
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): <input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed. <input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies <input checked="" type="checkbox"/> Project obligation will occur after permit issuance.
APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC, SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals

Are the following submittals up to date as applicable: <input checked="" type="checkbox"/> Cancer Registry <input checked="" type="checkbox"/> APORS <input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted <input checked="" type="checkbox"/> All reports regarding outstanding permits Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

NOT APPLICABLE

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available**. **Include observation days in the patient day totals for each bed service**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Memorial Hospital		CITY: Belleville			
REPORTING PERIOD DATES: From: January 1, 2014 to: December 31, 2014					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	175	12,698	55,595		175
Obstetrics	8	1,543	3,846		8
Pediatrics	14	9	29	(14)	0
Intensive Care	19	977	4,734		19
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:	216*	15,227	64,204	(14)	202

*Reflects adjustments made to the Inventory upon the approval of Project 11-017, addressing the establishment of Memorial Hospital-East.

//

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Protestant Memorial Medical Center d/b/a/ Memorial Hospital in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

Mark J. Turner
SIGNATURE

MARK J. TURNER
PRINTED NAME

PRESIDENT & CEO
PRINTED TITLE

Michael T. McManus
SIGNATURE

MICHAEL T. MCMAUS
PRINTED NAME

CHIEF OPERATING OFFICER
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 15th day of Dec, 2015

Notarization:
Subscribed and sworn to before me
this 17th day of Dec, 2015

Judy L. Lynch
Signature of Notary
Seal


Judy L. Lynch
Signature of Notary
Seal


*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Memorial Group, Inc. * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

Mark J Turner
 SIGNATURE
MARK J. TURNER
 PRINTED NAME
PRESIDENT & CEO
 PRINTED TITLE

Joe H. Lanius
 SIGNATURE
JOE H. LANIUS
 PRINTED NAME
Vice President & CFO
 PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 15th day of Dec. 2015

Notarization:
Subscribed and sworn to before me
this 17th day of Dec 2015

Judy L. Lynch
 Signature of Notary
 Seal
 OFFICIAL SEAL
 JUDY L LYNCH
 NOTARY PUBLIC - STATE OF ILLINOIS
 MY COMMISSION EXPIRES:04/30/18

Judy L. Lynch
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 MY COMMISSION EXPIRES:04/30/18

*Insert EXACT legal name of the applicant

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- o in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Memorial Regional Health Services, Inc.* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

Mark J. Turner
SIGNATURE

Michael T. McManus
SIGNATURE

MARK J. TURNER
PRINTED NAME

MICHAEL T. McMANUS
PRINTED NAME

PRESIDENT
PRINTED TITLE

DIRECTOR
PRINTED TITLE

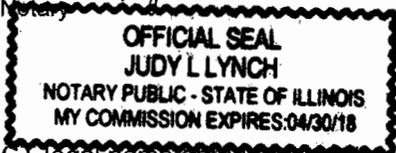
Notarization:
Subscribed and sworn to before me
this 15th day of Dec 2015

Notarization:
Subscribed and sworn to before me
this 17th day of Dec 2015

Judy L. Lynch
Signature of Notary

Judy L. Lynch
Signature of Notary

Seal



Seal



*Insert EXACT legal name of the applicant

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Steven H. Lipstein
SIGNATURE
Steven H. Lipstein
PRINTED NAME
President and CEO
PRINTED TITLE

Michael A. DeHaven
SIGNATURE
Michael A. DeHaven
PRINTED NAME
Senior Vice President and General Counsel
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 16th day of December 2015

Notarization:
Subscribed and sworn to before me
this 16th day of December 2015

Rita E. Long
Signature of Notary
Seal 
RITA E. LONG
My Commission Expires
February 21, 2017
St. Louis County
Commission #13668952

Rita E. Long
Signature of Notary
Seal 
RITA E. LONG
My Commission Expires
February 21, 2017
St. Louis County
Commission #13668952

*Insert EXACT legal name of the applicant

DISCONTINUATION

The applicants propose the discontinuation of Memorial Hospital's 14-bed Pediatrics category of service. No other clinical services will be discontinued. Memorial Hospital will continue to treat pediatrics patients on an outpatient basis, through its Emergency Department, and, as clinically appropriate, older pediatrics patients will be admitted to the hospital's Medical/Surgical units.

The proposed discontinuation is the result of low utilization of: 1) the hospital's Pediatrics unit (a total of 21 admissions between January 1, 2013 and December 31, 2014; and an average daily census of less than 0.2 patients), 2) industry trends toward the reliance on outpatient services for pediatrics and the concentrating of inpatient pediatrics services in children's hospitals, and 3) the availability of St. Louis Children's Hospital, which has been enhanced through Memorial Group, Inc. and BJC Healthcare's strategic affiliation, scheduled to close during the first quarter of 2016. As a result of the low historical utilization, the continued provision of outpatient services, and the availability of St. Louis Children's Hospital, the proposed discontinuation will result in no appreciable impact on accessibility. In addition, and also because of low historical utilization, the discontinuation of the pediatrics unit will not cause an undo strain on other hospitals' ability to accommodate pediatrics patients.

Discontinuation is anticipated to occur prior to April 1, 2016.

The future use/disposition of the pediatrics unit has not yet been determined. As appropriate, a limited amount of equipment currently in use on the unit, particularly beds and

furniture, will be re-used or held in reserve for future use. Other equipment will be sold, donated or discarded.

All medical records will be maintained by and accessible at Memorial Hospital, consistent with all applicable laws, licensure and accreditation requirements, and industry standards.

MEMORIAL GROUP INC.



Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, IL 62761

RE: Discontinuation of Pediatrics Category of Service
at Memorial Hospital, Belleville, IL

To Whom It May Concern:

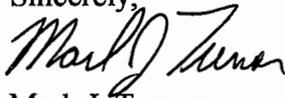
In accordance with Review Criterion 1130.520.b.3, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

Neither Memorial Group, Inc. nor any Illinois licensed health care facility affiliated with Memorial Group, Inc. has had any adverse actions against it during the three (3) year period prior to the filing of this application.

Memorial Group, Inc. authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1130.520.b.3 or to obtain any documentation or information which the State Board or Agency finds pertinent to this COE application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

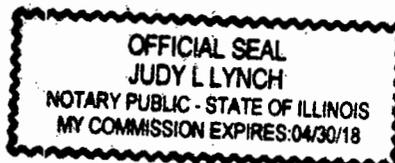
Sincerely,



Mark J. Turner
President and CEO

Date: 12.15.15

Notarized: *Judy L. Lynch*



SAFETY NET STATEMENT

Memorial Hospital is a major provider of safety net services, and the proposed discontinuation of the hospital's Pediatrics category of service will have no appreciable impact on the provision of safety net services.

During 2014 6.4% of Memorial Hospital's admissions were categorized as charity care and 11.3% were Medicaid recipients. In excess of \$35M in community benefits were provided by Memorial Hospital during 2014, including: the unpaid costs associated with Medicare and Medicaid, incurred bad debt, charity care, subsidized health care services, clinics and screenings provided, wellness and educational programs, support groups, monetary donations, participation in health fairs and other community events, and language assistance programs. These programs directly impacted in excess of 23,000 lives.

As discussed in other portions of this application, the utilization of inpatient pediatrics services at Memorial Hospital has been minimal in recent years, consistent with national trends. As a result, the proposed discontinuation of the pediatrics category of service is not anticipated to have any appreciable impact on other providers, or their ability to provide safety net services.